Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 12/2/03.

I. DISPUTE

Whether there should be reimbursement for CPT code 99141 (sedation with or without analgesia) for date of service 8/21/03.

II. RATIONALE

Commission Rule 134.202 (b), Medical Fee Guideline, effective 8/1/03, states that, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a services is provided with any additions or exceptions in this section." To determine the maximum allowable reimbursement (MAR) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: Rule 134.202 (c) (1) states, "For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology. The conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by Centers for Medicare and Medicaid Services multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

The service in dispute was denied as, "G, B377-This is a bundled procedure; no separate payment allowed".

Requestor states on the table of disputed services, "Not global to any other procedure code and is billed fair and reasonable according to documentation."

Carriers statement of position dated 12/19/03 states in part, "…. CPT 99141 is denied per the new MFG which went into effect 8/1/03. Per the Medicare Correct Coding Guide, "When anesthesia is provided by the physician performing the primary service, the anesthesia services are included in the primary procedure."

The Medicare Part B Correct Coding Guide, Number (F), in the General Correct Coding Policies, state that, "Under the National Global Surgical Policy, Medicare does not allow separate payment for the anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is made through the payment for the medical or surgical service."

III. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 29th day of January 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc